FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040923

Facility Name: Lexington of Wheeling

Address: 730 W. Hintz Road (Number) Wheeling (City) 60090 (Zip Code)

County: Cook

Telephone Number: (847) 537-7474 **Fax #** (847) 537-7599

IDPA ID Number: 363885225001

Date of Initial License for Current Owners: 05/12/95

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		x	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** 312-634-3400
Altschuler, Melvoin & Glasser LLP
One South Wacker Drive
Chicago, IL 60606-3392
Please send copies of any desk review or audit adjustments to the above address.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) Altschuler, Melvoin & Glasser LLP, One South Wacker Drive, Chicago, Il 60606-3392
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 1/1/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 3/24/00

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	211	Skilled (SNF)	221	80,056	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	211	TOTALS	221	80,056	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	36,883	5,287	4,307	46,477	8
9	SNF/PED					9
10	ICF	22,720	2,648	656	26,024	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	59,603	7,935	4,963	72,501	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.56%

D. How many bed-hold days during this year were paid by Public Aid?
74 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 05/12/95

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [x] New construction

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 32 and days of care provided 3,492

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7 **	8	9	10	
	A. General Services											
1	Dietary	306,478	41,267	15,214	362,959		362,959		362,959			1
2	Food Purchase		285,643		285,643		285,643	(11,607)	274,036			2
3	Housekeeping	287,219	40,129		327,348		327,348		327,348			3
4	Laundry	52,829	28,139		80,968		80,968	(1,658)	79,310			4
5	Heat and Other Utilities			145,400	145,400		145,400	2,224	147,624			5
6	Maintenance	76,344		101,330	177,674		177,674	1,844	179,518			6
7	Other (specify):*											7
8	**TOTAL General Services**	722,870	395,178	261,944	1,379,992		1,379,992	(9,197)	1,370,795			8
	B. Health Care and Programs											
9	Medical Director			4,800	4,800		4,800		4,800			9
10	Nursing and Medical Records	2,855,640	215,768	32,368	3,103,776		3,103,776		3,103,776			10
10a	Therapy			532,161	532,161		532,161		532,161			10a
11	Activities	172,822	17,912	3,232	193,966		193,966	18	193,984			11
12	Social Services	61,635		2,773	64,408		64,408		64,408			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,090,097	233,680	575,334	3,899,111		3,899,111	18	3,899,129			16
	C. General Administration											
17	Administrative	147,902		375,801	523,703		523,703	(375,801)	147,902			17
18	Directors Fees											18
19	Professional Services			51,226	51,226		51,226	(4,643)	46,583			19
20	Dues, Fees, Subscriptions & Promotions			33,387	33,387		33,387	4,213	37,600			20
21	Clerical & General Office Expenses	340,180	32,012	20,506	392,698		392,698	17,824	410,522			21
22	Employee Benefits & Payroll Taxes			492,179	492,179		492,179	55,356	547,535			22
23	Inservice Training & Education							276	276			23
24	Travel and Seminar			3,077	3,077		3,077	500	3,577			24
25	Other Admin. Staff Transportation							8,644	8,644			25
26	Insurance-Prop.Liab.Malpractice			45,672	45,672		45,672	1,766	47,438			26
27	Other (specify):*											27
28	**TOTAL General Administration**	488,082	32,012	1,021,848	1,541,942		1,541,942	(291,865)	1,250,077			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,301,049	660,870	1,859,126	6,821,045		6,821,045	(301,044)	6,520,001			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**** See schedule of adjustments attached at end of cost report.**

Facility Name & ID Number Lexington of Wheeling #0040923 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7 **	8	9	10	
	D. Ownership											
30	Depreciation			24,667	24,667		24,667	218,453	243,120			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			156	156		156	417,712	417,868			32
33	Real Estate Taxes							385,524	385,524			33
34	Rent-Facility & Grounds			1,574,589	1,574,589		1,574,589	(1,574,589)				34
35	Rent-Equipment & Vehicles			711	711		711	378	1,089			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,600,123	1,600,123		1,600,123	(552,522)	1,047,601			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		66,105	19,299	85,404		85,404		85,404			39
40	Barber and Beauty Shops			38,942	38,942		38,942		38,942			40
41	Coffee and Gift Shops			1,767	1,767		1,767		1,767			41
42	Provider Participation Fee			120,085	120,085		120,085		120,085			42
43	Other (specify):* **Nonallowable costs**			7,000	7,000		7,000	(7,000)				43
44	**TOTAL Special Cost Centers**		66,105	187,093	253,198		253,198	(7,000)	246,198			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,301,049	726,975	3,646,342	8,674,366		8,674,366	(860,566)	7,813,800			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 1/1/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(119)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(1,658)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(11,605)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(916)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(25)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	14,943	43		24
25	Fund Raising, Advertising and Promotional	(10,502)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(10,046)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule A	(12,028)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (31,956)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(828,610)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (828,610)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (860,566)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Lexington of Wheeling

ID# 0040923

Report Period Beginning: 1/1/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
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41				41
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70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	0		90

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Samatas	33.33%			Lexington Health	Wheeling	Real estate ptsp.
John Samatas	33.33%	See attached Schedule B		Care Systems of		
Cynthia Thiem	33.34%			Wheeling Ltd. Ptsp.		
				Royal Mgmt. Corp.	Lombard	Mgmt. Co.
				Lexington Financial	Lombard	Finance Co.
				Services, LL.C.II		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental expense	$ 1,574,589	Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	$	$ (1,574,589)	1
2	V	30	Depreciation		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	206,195	206,195	2
3	V	32	Interest expense		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	423,645	423,645	3
4	V	32	Amortization of mortgage costs		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	3,653	3,653	4
5	V	33	Property taxes		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	374,589	374,589	5
6	V	43	State replacement tax		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	46	46	6
7	V	21	Bank charges		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	75	75	7
8	V	19	Professional fees		Lexington Health Care Systems of Wheeling Ltd. Ptsp.	**	9,472	9,472	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,574,589			$ 1,017,675	$ * (556,914)	14

** The owners of Lexington Health Care Center of Wheeling, Inc. own 100% of Lexington Health Care Systems of Wheeling Limited Partnership

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	FICA	$	Royal Management Corp.	**	$ 23,602	$ 23,602	15
16	V	22	FUTA		Royal Management Corp.	**	489	489	16
17	V	22	SUTA		Royal Management Corp.	**	1,317	1,317	17
18	V	22	Insurance - W/C		Royal Management Corp.	**	278	278	18
19	V	22	Insurance - Hospitalization		Royal Management Corp.	**	11,935	11,935	19
20	V	22	401 (k) and other emp. Benefits		Royal Management Corp.	**	6,247	6,247	20
21	V	30	Depreciation - vehicles		Royal Management Corp.	**	3,931	3,931	21
22	V	30	Depreciation - leasehold improv.		Royal Management Corp.	**	2,180	2,180	22
23	V	30	Depreciation - equipment		Royal Management Corp.	**	6,147	6,147	23
24	V	33	Property taxes		Royal Management Corp.	**	1,528	1,528	24
25	V	6	Repairs & maintenance		Royal Management Corp.	**	1,261	1,261	25
26	V	26	Insurance - general		Royal Management Corp.	**	1,766	1,766	26
27	V	6	Scavenger & exterminating		Royal Management Corp.	**	568	568	27
28	V	5	Utilities - gas & electric		Royal Management Corp.	**	1,858	1,858	28
29	V	5	Utilities - water & sewer		Royal Management Corp.	**	366	366	29
30	V	11	Activities Consultant		Royal Management Corp.	**	18	18	30
31	V	35	Equipment rental		Royal Management Corp.	**	378	378	31
32	V	20	Advertising - help wanted		Royal Management Corp.	**	3,638	3,638	32
33	V	25	Auto expense		Royal Management Corp.	**	8,644	8,644	33
34	V	21	Bank charges		Royal Management Corp.	**	273	273	34
35	V	19	Computer consultant & supplies		Royal Management Corp.	**	5,349	5,349	35
36	V	20	Dues & subscriptions		Royal Management Corp.	**	575	575	36
37	V	21	Office supplies & printing		Royal Management Corp.	**	6,941	6,941	37
38	V	21	Postage		Royal Management Corp.	**	2,591	2,591	38
39	Total			$			$ 91,880	$ * 91,880	39

** Certain owners of Lexington Health Care Center of Wheeling, Inc own 100% of Royal Management Corp.

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional fees	$	Royal Management Corp.	**	$ 1,252	$ 1,252	15
16	V	6	Security service		Royal Management Corp.	**	15	15	16
17	V	21	Telephone		Royal Management Corp.	**	7,409	7,409	17
18	V	21	Communications		Royal Management Corp.	**	535	535	18
19	V	24	Travel & seminar		Royal Management Corp.	**	719	719	19
20	V	32	Interest		Royal Management Corp.	**	2,019	2,019	20
21	V	23	Training & education		Royal Management Corp.	**	276	276	21
22	V	17	Management fees	375,801	Royal Management Corp.	**		(375,801)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 375,801			$ 12,225	$ * (363,576)	39

** Certain owners of Lexington Health Care Center of Wheeling, Inc own 100% of Royal Management Corp.

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	James Samatas	Owner/officer	Administrative	33.33%	See Schedule C	5	10.00%	Salary	$ 27,398	L17, C1	1
2	John Samatas	Owner/officer	Admin/Plant Ops	33.33%	See Schedule C	2	4.00%	Salary	12,178	L17, C1	2
3	Cynthia Thiem	Owner/officer	Administrative	33.34%	See Schedule C	2	5.00%	Salary	15,222	L17, C1	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	2	4.00%	Salary	4,870	L17, C1	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	5	12.50%	Salary	8,097	L17, C1	5
6											6
7						All individuals work in excess of 40 hours per week.					7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 67,765		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 1300 S. Main Street
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 495-1700
Fax Number: (630) 495-4424

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	FICA	Bed Days	788,945	11	$ 232,594	$	80,056	$ 23,602	1
2	22	FUTA	Bed Days	788,945	11	4,830		80,056	489	2
3	22	SUTA	Bed Days	788,945	11	12,967		80,056	1,317	3
4	22	Insurance - W/C	Bed Days	788,945	11	2,735		80,056	278	4
5	22	Insurance - Hospitalization	Bed Days	788,945	11	117,633		80,056	11,935	5
6	22	401 (k) and other emp. Benefits	Bed Days	788,945	11	61,535		80,056	6,247	6
7	30	Depreciation - vehicles	Bed Days	788,945	11	38,735		80,056	3,931	7
8	30	Depreciation - leasehold improv.	Bed Days	788,945	11	21,505		80,056	2,180	8
9	30	Depreciation - equipment	Bed Days	788,945	11	60,561		80,056	6,147	9
10	33	Real estate taxes	Bed Days	788,945	11	15,061		80,056	1,528	10
11	6	Repairs & maintenance	Bed Days	788,945	11	12,408		80,056	1,261	11
12	26	Insurance - general	Bed Days	788,945	11	17,396		80,056	1,766	12
13	6	Scavenger & exterminating	Bed Days	788,945	11	5,608		80,056	568	13
14	5	Utilities - gas & electric	Bed Days	788,945	11	18,291		80,056	1,858	14
15	5	Utilities - water & sewer	Bed Days	788,945	11	3,608		80,056	366	15
16	11	Activity consultant	Bed Days	788,945	11	167		80,056	18	16
17	35	Equipment rental	Bed Days	788,945	11	3,709		80,056	378	17
18	20	Advertising - help wanted	Bed Days	788,945	11	35,848		80,056	3,638	18
19	25	Auto expense	Bed Days	788,945	11	85,184		80,056	8,644	19
20	21	Bank charges	Bed Days	788,945	11	2,695		80,056	273	20
21	19	Computer consultant & supplies	Bed Days	788,945	11	52,718		80,056	5,349	21
22	20	Dues & subscriptions	Bed Days	788,945	11	5,668		80,056	575	22
23	21	Office supplies & printing	Bed Days	788,945	11	68,404		80,056	6,941	23
24	21	Postage	Bed Days	788,945	11	25,535		80,056	2,591	24
25	TOTALS					$ 905,395	$		$ 91,880	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

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Name of Related Organization: Royal Management Corp.
Street Address: 1300 S. Main Street
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Fax Number: (630) 495-4424

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional fees	Bed Days	788,945	11	$ 12,334	$	80,056	$ 1,252	1
2	6	Security Service	Bed Days	788,945	11	127		80,056	15	2
3	21	Telephone	Bed Days	788,945	11	73,022		80,056	7,409	3
4	21	Communications	Bed Days	788,945	11	5,248		80,056	535	4
5	24	Travel & seminar	Bed Days	788,945	11	7,077		80,056	719	5
6	32	Interest	Bed Days	788,945	11	19,899		80,056	2,019	6
7	23	Training & Education	Bed Days	788,945	11	2,716		80,056	276	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 120,423	$		$ 12,225	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Lexington Financial						$	$			$	1
2	Services, L.L.C. II	X		Mortgage	$49,514	12/29/98	6,513,000	6,197,519	12/29/08	0.0675	423,645	2
3												3
4												4
5												5
	Working Capital											
6	Shareholders	X		Working Capital	None	Various	587,000	120,000	Demand	0.0550	156	6
7												7
8												8
9	TOTAL Facility Related				$49,514		$ 7,100,000	$ 6,317,519			$ 423,801	9
	B. Non-Facility Related*											
10								Amortization of loan costs			3,653	10
11								Interest income offset			(11,605)	11
12								Allocated from management company			2,019	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (5,933)	14
15	TOTALS (line 9+line14)						$ 7,100,000	$ 6,317,519			$ 417,868	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.		$ 383,000	1
Allocated from management company		1,528	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	1999	$ 373,589	2
3. Under or (over) accrual (line 2 minus line 1).		$ (7,883)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 384,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$ 9,407	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 385,524	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	138,115	8
	1996	265,869	9
	1997	375,879	10
	1998	365,183	11
	1999	373,589	12

1999 taxes:	373,589
Estimated increase (3%):	1.03
Estimated 2000 taxes:	384,797
Use:	384,000

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 1/1/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 85,551 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	137,650	1993	$ 595,000	1
2					2
3	TOTALS	137,650		$ 595,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	211		1995	1995	$ 6,537,447	$	10-40	$ 164,075	$ 164,075	$ 922,925	4
5	10		2000	2000	98,710	1,234	40	1,234		1,234	5
6											6
7											7
8											8
	Improvement Type**										
9	Building improvement			1995	3,587		15	239	239	1,346	9
10	Land improvement - sidewalk replacement			1996	1,927	128	15	128		578	10
11	Leasehold improvement - pines & sod			1996	3,432	229	15	229		1,030	11
12	Basement rehab			1997	18,611	1,860	10	1,860		6,513	12
13	Building improvement - curtains/track			1997	1,936		35	55	55	194	13
14	Landscaping			1997	2,002	134	15	134		468	14
15	Wiring for MDS			1998	3,552	355	10	355		888	15
16	Parking Lot			1998	2,952	294	10	294		737	16
17	Roof repair			2000	1,980	99	10	99		99	17
18	Remodel HVAC/exhaust system - office area			2000	7,480	187	20	187		187	18
19	Automatic Door			2000	1,300	65	10	65		65	19
20	Rods for beside curtains			2000	2,525	126	10	126		126	20
21	Floor tile			2000	10,298	515	10	515		515	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 6,697,739	$ 5,226		$ 169,595	$ 164,369	$ 936,905	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocated from management company			1995	10,329		35	319	319	1,624	9
10	Allocated from management company			1996	8,407		35	260	260	1,079	10
11	Allocated from management company			1989	290		31	9	9	115	11
12	Allocated from management company - HVAC			1998	218		35	7	7	19	12
13	Allocated from management company - offices			1999	549		35	17	17	24	13
14	Allocated from management company -offices			2000	261		35	8	8	4	14
15	Allocated from management company			1987	48,285		31	1,490	1,490	19,613	15
16	Allocated from management company			1993	27		39	1	1	4	16
17	Allocated from management company			1995	1,086		39	34	34	151	17
18	Allocated from management company			1996	220		39	7	7	23	18
19	Allocated from management company - Sidewalk			1998	455		39	14	14	27	19
20	Allocated from management company - Roof			1998	17		15	1	1	4	20
21	Allocated from management company - Awnings			1999	281		39	9	9	40	21
22	Allocated from management company - Parking lot			1999	128		15	4	4	5	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 70,553	$		$ 2,180	$ 2,180	$ 22,732	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 540,589	$ 17,553	$ 59,379	$ 41,826	5-10 years	$ 272,050	37
38	Current Year Purchases	18,867	1,888	1,888		5-10 years	1,888	38
39	Fully Depreciated Assets							39
40	Allocation from management company	60,546		6,147	6,147		42,846	40
41	TOTALS	$ 620,002	$ 19,441	$ 67,414	$ 47,973		$ 316,784	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45	Allocation from management company			26,228		3,931	3,931		16,121	45
46	TOTALS			$ 26,228	$	$ 3,931	$ 3,931		$ 16,121	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 8,009,522	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 24,667	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 243,120	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 218,453	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,292,542	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: [ ] YES [ ] NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 1,089 Description: Postage meter: $711; Allocation from management company: $378
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	16,320	$ 236,935	$	16,320	$ 236,935	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		7,360	56,487		7,360	56,487	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		20,684	238,739		20,684	238,739	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				66,105		66,105	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Oxygen, Lab Other (specify): Clinitron Beds	L39, C3 L39, C3				7,295 12,004			7,295 12,004	13
14	TOTAL			$	44,364	$ 551,460	$ 66,105	44,364	$ 617,565	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 5,920	$ 3,600	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 414,499)	1,962,878	1,962,878	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,300	21,300	6
7	Other Prepaid Expenses	413	413	7
8	Accounts Receivable (owners or related parties)	31,272	31,272	8
9	Other(specify): See attached Schedule D		130,235	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,021,783	$ 2,149,698	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	5,284	5,284	12
13	Land		595,000	13
14	Buildings, at Historical Cost		6,528,926	14
15	Leasehold Improvements, at Historical Cost	154,769	239,366	15
16	Equipment, at Historical Cost	141,193	646,230	16
17	Accumulated Depreciation (book methods)	(58,343)	(1,292,542)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Unamortized mortgage costs		65,749	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 242,903	$ 6,788,013	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,264,686	$ 8,937,711	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 226,172	$ 235,579	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	120,000	120,000	29
30	Accrued Salaries Payable	159,604	159,604	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,804	3,804	31
32	Accrued Real Estate Taxes(Sch.IX-B)		384,000	32
33	Accrued Interest Payable	156	35,017	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule D	457,771	172,891	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 967,507	$ 1,110,895	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		6,197,519	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 6,197,519	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 967,507	$ 7,308,414	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,297,179	$ 1,629,297	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,264,686	$ 8,937,711	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 442,853	1	
2	Restatements (describe):		2	
3	**Prior year post closing entries**	741,730	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,184,583	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	999,654	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(887,058)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 112,596	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,297,179	24	*

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,954,880	1
2	Discounts and Allowances for all Levels	(390,451)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,564,429	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	826,688	6
7	Oxygen	(1,862)	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 824,826	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	4,453	12
13	Barber and Beauty Care	49,711	13
14	Non-Patient Meals	119	14
15	Telephone, Television and Radio	235	15
16	Rental of Facility Space		16
17	Sale of Drugs	86,249	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,869	19
20	Radiology and X-Ray		20
21	Other Medical Services	112,380	21
22	Laundry	1,658	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 261,674	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11,605	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,605	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached Schedule D	11,486	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 11,486	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,674,020	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,379,992	31
32	Health Care	3,899,111	32
33	General Administration	1,541,942	33
	B. Capital Expense		
34	Ownership	1,600,123	34
	C. Ancillary Expense		
35	Special Cost Centers	133,113	35
36	Provider Participation Fee	120,085	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,674,366	40
41	**Income before Income Taxes (line 30 minus line 40)****	999,654	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 999,654	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. This entity files a cash basis tax return.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,307	1,408	$ 40,687	$ 28.90	1
2	Assistant Director of Nursing	4,086	4,324	104,815	24.24	2
3	Registered Nurses	50,976	53,778	1,257,924	23.39	3
4	Licensed Practical Nurses	12,131	12,830	243,260	18.96	4
5	Nurse Aides & Orderlies	92,158	95,215	1,126,743	11.83	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,062	7,346	82,211	11.19	8
9	Activity Director	2,002	2,082	31,525	15.14	9
10	Activity Assistants	16,994	17,571	141,297	8.04	10
11	Social Service Workers	4,001	4,162	61,635	14.81	11
12	Dietician	201	213	4,354	20.44	12
13	Food Service Supervisor	1,785	1,817	26,507	14.59	13
14	Head Cook	2,068	2,109	22,011	10.44	14
15	Cook Helpers/Assistants	18,741	19,391	119,887	6.18	15
16	Dishwashers	15,833	16,629	133,719	8.04	16
17	Maintenance Workers	4,106	4,433	76,344	17.22	17
18	Housekeepers	40,963	43,144	287,219	6.66	18
19	Laundry	8,071	8,473	52,829	6.23	19
20	Administrator	2,058	2,099	80,137	38.18	20
21	Assistant Administrator					21
22	Other Administrative	658	678	67,765	99.95	22
23	Office Manager					23
24	Clerical	20,006	21,432	340,180	15.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	305,207	319,134	$ 4,301,049 *	$ 13.48	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 15,214	L1, C3	35
36	Medical Director	Monthly	4,800	L9, C3	36
37	Medical Records Consultant	21	1,050	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	3,232	L11, C3	44
45	Social Service Consultant	Monthly	2,773	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	21	$ 28,269		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	3,196	27,167	L10, C3	52
53	TOTAL (lines 50 - 52)	3,196	$ 27,167		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Deborah Randon	Administrator	0.00%	$ 80,137
John Samatas	Admin/Plant Ops	33.33%	12,178
James Samatas	Administrative	33.33%	27,398
Cythia Thiem	Administrative	33.34%	15,222
George Samatas	Administrative	0.00%	4,870
Jason Samatas	Administrative	0.00%	8,097
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 147,902

B. Administrative - Other

Description	Amount
Management fees (eliminated fees)	$ 375,801
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 375,801

C. Professional Services

Vendor/Payee	Type	Amount
Aetna Life Insurance & Annuity Co.	401(k) Administration	$ 555
Altschuler, Melvoin, & Glasser, LLP	Accounting	13,486
American Express Tax & Bus. Svs.	Accounting	5,926
Christine Toolan, R.R.A.	Consulting	60
Holleb & Coff	Legal	3,743
James Samatas	Legal	50
Personnel Planners	U/C Consulting	775
Royal Management	Website Development	338
Sachnoff & Weaver	Legal	229
Systematic Management	Billing Consulting	11,622
Commitment Consulting	Collections	429
See attached Schedule E		14,013
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 51,226

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 46,044
Unemployment Compensation Insurance	32,616
FICA Taxes	317,339
Employee Health Insurance	85,036
Employee Meals	11,488
Illinois Municipal Retirement Fund (IMRF)*	
401(k) contribution	20,525
CNA Transportation	28,440
Other employee benefits	6,047
TOTAL (agree to Schedule V, line 22, col.8)	$ 547,535

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	31,253
Health Care Worker Background Check	
(Indicate # of checks performed 26)	312
Miscellaneous dues & subs	484
Miscellaneous licenses, permits	
and inspections	1,338
	.
Allocation from management company	4,213
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 37,600

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,858
Allocation from management company	719
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,577

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lexington of Wheeling # 0040923 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6						N/A							
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Wheeling # 0040923 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **72,473** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **120,085**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **11,488** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **119**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records are maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.